Hepatobiliary & Upper GI (HPB & UGI)

Oldham Care Organisation
Northern Care Alliance
NHS Founsation Trust

Is The Faster Diagnosis Standard, Fast Enough?

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The Challenge:

To achieve NHS England's target of ensuring a patient is ***waiting no longer than 28 days*** from initial referral to receiving or ruling out a cancer diagnosis.

Macmillian HPB/UGI Cancer Team

Debbie Clark, Katie Dennison, Christina Hall, Leah Hamilton

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The case for change:

• Suspicion of Upper GI (UGI) HPB and oesophogo-gastric (OG) cancer is the sixth most common urgent referral in England, representing 7.5% of cancer referrals in 2020.
• Between 2018 and 2019 70% of patients diagnosed with HPB and OG cancer commenced treatment within 62 days of referral.
• Between 2020 and 2021 this was 64% although likely exacerbated by COVID -19, performance had already been in decline.
• HPB cancers affect more than 17,000 people each year, with more than 14,000 people dying each year.
• UGI cancers affect more than 16,000 people each year with more than 14,000 people dying each year.

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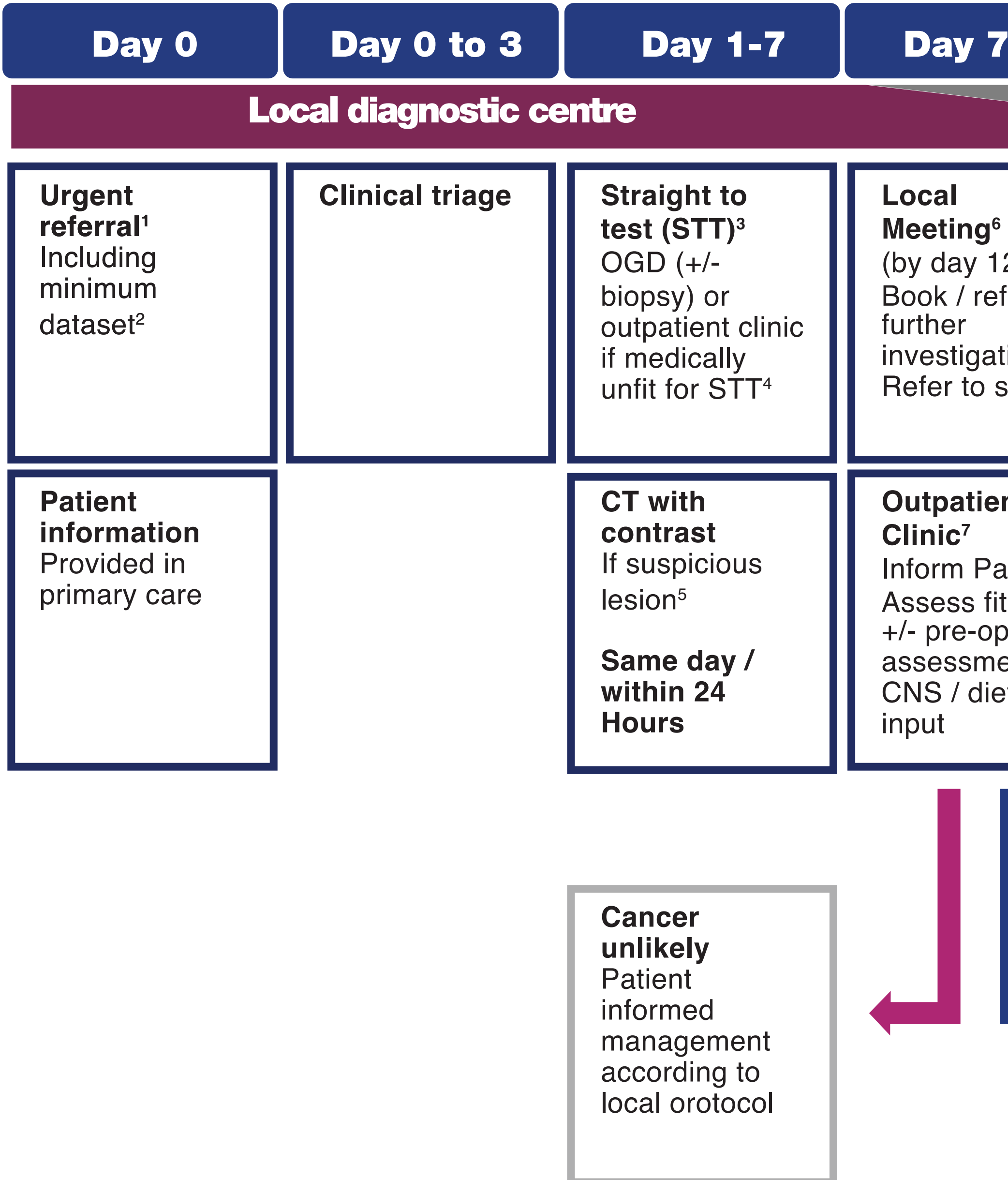
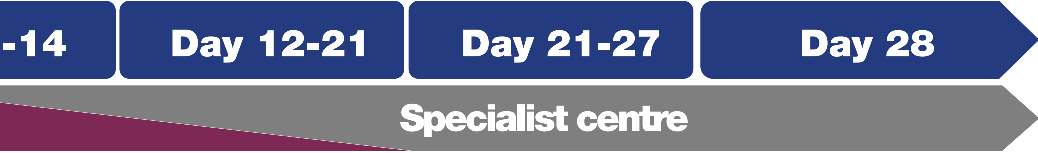
The UGI FDS Timeline





2)
er for

ions;
MDT

Further Investigations
Oesophageal/
GOJ: PET-CT
Gastric: see local agreement[9]

Further Investigations
If required
Laparoscopy
+/- EUS

Outpatient Clinic MDT input;
assess fitness +/- pre-op assessment;
Patient optimisation and support[11]

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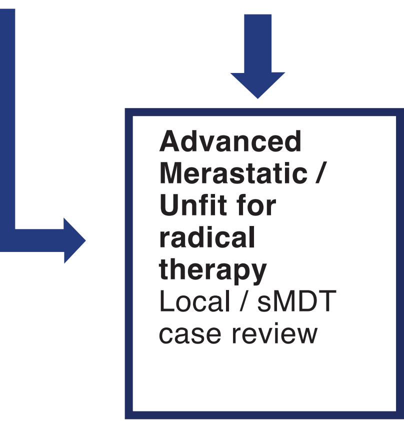
titian

sMDT[10]

Communication to patient[12]
Discuss treatment options and Personalised Care and Support Plan



Th

Proc

GM Cancer funded WTE
1.5 Best-Timed Pathway (BTP)
Triage Nurses.

01

The team developed guidelines, and an algorithm to support the Nurse-Led Telephone Triage (NLT) service.

02

NLT carried out to assess if patients were fit for Straight To Test (STT) and organised relevant investigations on behalf of the Gastroenterologist.

03

Refer patients unfit for Straight To Test,for face to face/ Telephone Consultant assessment.

04

ne

cess

08

Ensured timely MDT discussion inclusive of the patient's impact statement. Resulting in improved patient experience.

07

BTP clinic, provided Clinical Nurse Specialist (CNS) and dietetic support.

06

Introduced the BTP Nurse-led face-to-face assessment clinic for patients who had been told at endoscopy of a likely cancer.

05

12 patients with painless jaundice redirected to the "Rapid Diagnostic Centre" (RDC) 2022-2023 resulted in 4 HPB cancers diagnosed.

Outcomes

Total number of UGI referrals per year on average is 5000

Between April 2022–March 2023
There were 4,951patients triaged,
averaging 413 patients per month.

Between April 2023-January 2024
There were 2,940 patients triaged,
averaging 294 patient per month.

The data below highlights the impact of the NLT service to diagnose or rule out UGI cancer.

Pre Triage	**12 day wait from GP referral to NLT appointment** **15 day wait for STT**
Post Triage	**5 day wait from GP referral to NLT appointment** **12 day wait for STT (capacity issues)**

Somerset– Two Week Wait Report	Triaged in 7 days or less	Triaged in 14 days or less
April 2022 March 2023	74.2%	95.7%
April 2023 January 2024	83.9%	98.1%

How the service has improved:

Suspected Cancer upgrade referral's are triaged by the Upper GI CNS team on the day of upgrade, previously these patients would have been actioned within a two week window.

Working closely with cancer services the team developed guidelines to support the pathway navigators to identify patient's on the electronic referral system (ERS) not suitable for NLT and redirect to consultant / RDC appointment.

What we have found:

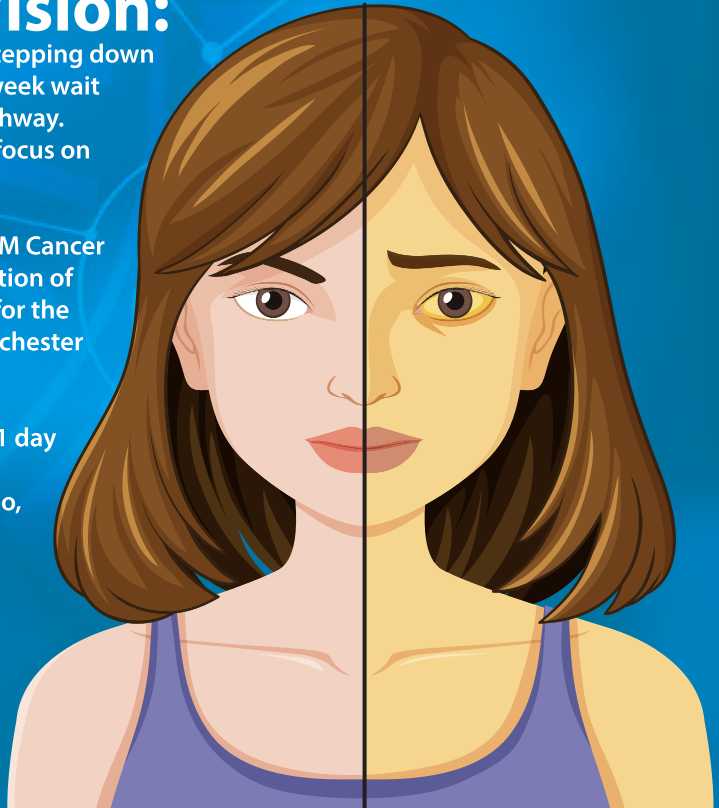
The improvement in the service with timely referrals, timely diagnostics and patient communication has resulted in improved patient outcomes, patient experience and therefore reduced real world costs to the NHS as a whole.

Future Vision:

CNS involvement in stepping down patients off the two-week wait Suspected Cancer Pathway. Allowing clnicians to focus on other areas.

With the support of GM Cancer Funding, implementation of a One Stop OG Clinic for the whole of Greater Manchester and Cheshire.

Implement the HPB 21 day jaundice, pancreatice, extrahepatic cholangio, gall bladder FDS.



The HPB FDS Timeline

21-day jaundice, pancreatic, extra

Day 0	By Day 5	By Day 8
Primary care	Local Diagnostic Centre	

Urgent referral based on NG12 NICE guidelines[1] including minimum dataset [2]

→ **Straight to test:** **Contrast CT**[3] with hot reporting (72hrs), **Bloods, including tumour markers**[3] and commence **Pancreatic Enzyme Replacement Therapy (PERT)** if required[3,15] Outpatient appointment if not suitable for straight to CT[5]

→ **Clinical assessment of CT results** by suitably experienced HPB clinician[6] and commence **endoscopic retrograde cholangiopancreatography (ERCP), brushings and stent** if clinically indicated. Or fast track treatment referral for respectable patient, if required[7]

Booking of Contrast MRI, MRCP, Fluorodeoxyglucose PET-CT, or Laparoscopy / Laparoscopic Ultrasound, if required[7]

Secondary care

Emergency presentation and referrals from radiology[1]

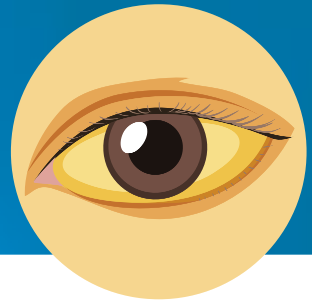
Patient information Provided in primary care[1]

→ **Patient information** Provided in clinic / OPA [5]

→ **Cancer ruled out and communicatio**
has been excluded. Note there are sign

Referred to other secondary care servi
Cancer likely / diagnosed; Outpatien
Record FDS if patient is informed they
specialist MDT input, Discuss treatmen

Personalised Care and Support Plan di
management, identify physical, psycho
prehabilitation, occupational, nutritional



hepatic cholangio, gall bladder

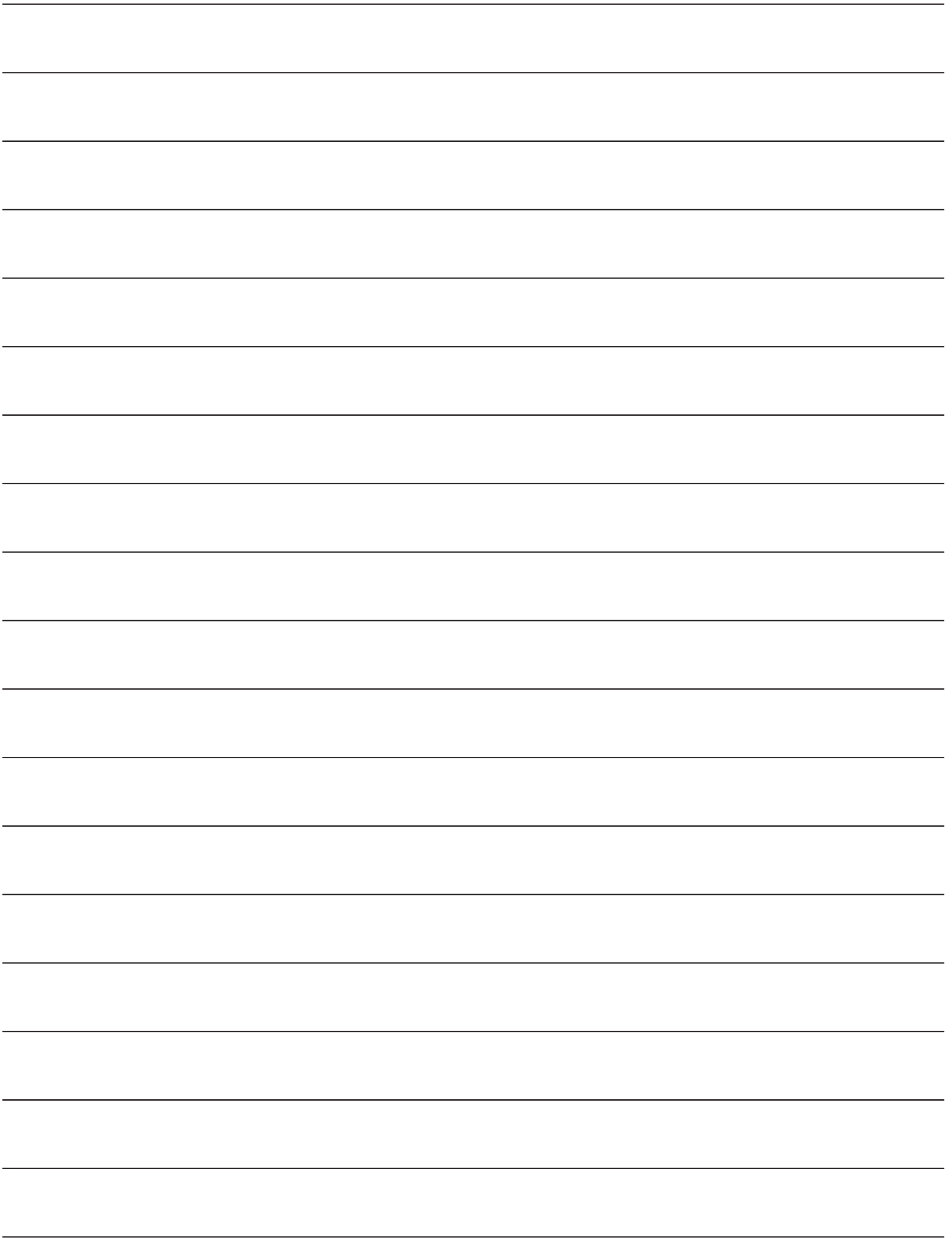
By Day 10	By Day 16	By Day 21
/ Specialist Diagnostic Centre		
Local or specialised MDT using agreed standard of care pathways to minimise MDT discussions[9] **Booking of ERCP, or EUS guided FNA Biopsy** if decided by MDT[7]	**Contrast MRI[4] or MRCP[10]** **Fluorodeoxyglucose PET-CT or** selective **Laparoscopy / Laparoscopic Ultrasound** when resection planned[11] **Endoscopic Retrograde Cholangiopancreatography (ERCP)** (or other billiary drainage procedure) or **Endoscopic Ultrasound guided FNA Biopsy[12]**	**Confirmation of treatment plan** and **Ongoing Personalised Care and Support Plan** discussion with patient[13,14] Access to a HPB specialist dietitian Referral to prehabilitation programme, if indicated Clinical trial enrolment considered

n **to patient**; Record FDS if patient informed that all cancer
nificant 'overlap' for upper GI symptoms.

ce or discharge [8] OR
t **Clinic and communication to patient**;
have cancer. Discussion with HPB specialist, CNS and
t options, subject to staging testing being reported;

scussion with patient [8] HPB CNS to discuss symptom
logical and nutritional care needs as well as refer for any
 or psychological support and required.

NOTES



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